ence Library

OCT 18 1947

BULLETIN of the MENNINGER CLINIC

Vol. 11, No. 5 September, 1947

Contents:

DERMATOLOGY NUMBER

Observations of a Psychiatrist in a Dermatology Clinic. *By* Karl A. Menninger, M.D..... 141

The Psychological Aspects of Skin Disease. *By* Eric D. Wittkower, M.D..... 148

I. Seborrhoeic Dermatitis
II. Psoriasis
III. Pompholyx

Psychoanalytic Observations on Skin Disorders. *By* Bela Mittelmann, M.D..... 169

Announcement 177

Book Notices..... 178

Topeka
Kansas

Issued bi-monthly by the Menninger Foundation, Topeka, Kansas
Annual Subscription rate $3.00. Single numbers, 50c
Copyright 1947 The Menninger Foundation

BULLETIN of the
MENNINGER CLINIC

VOLUME 11 SEPTEMBER, 1947 NUMBER 5

OBSERVATIONS OF A PSYCHIATRIST IN A DERMATOLOGY CLINIC*

By KARL MENNINGER, M.D.

As a psychiatrist I have spent many hours in listening—listening to subjective descriptions of internal, invisible "lesions." An opportunity for a different type of clinical experience came when I received from Dr. Paul O'Leary of the Mayo Clinic an invitation to spend six weeks in the Dermatology Section of that great medical center to which come so many patients who present their quite visible lesions in eloquent silence. My experiences there were in the nature of orientation rather than the pursuit of a definite research objective. My listening experience stood me in good stead, but I had much to see that was new to my eyes and much to learn about the emotional atmosphere of the dermatological clinic, quite apart from the psychological factors in specific cases.

When an observer enters such a clinic, he is almost immediately aware of a characteristic atmosphere. The patients awaiting help give evidence of a controlled but anxious desperation, quite different in its nature from the more dramatic depression and anxiety of the surgical clinic, or the more placid resignation of the medical clinic. These "skin patients" are for the most part not threatened with death, paralysis, loss of vision, or other such catastrophes. But the limiting boundary of their personality, the skin, has become diseased; and something psychologically more important than locomotion or digestion is affected—namely, appearance. Their affliction is usually no secret. Its very obviousness is one of the chief sources of the patient's distress. To the sensory discomfort or pain which such patients suffer, there is added the mortification of exhibiting a more or less repulsive and suspicious lesion which marks and segregates them immediately. It subjects them to countless conjectures as to cause, implications, consequences, and treatment by curious, meddlesome, or even well intentioned acquaintances. Sympathy is apt to be only secondary to fear in the observer. The tacit assumption of filth, lice, syphilis, or contagion—regardless of its injustice—tends to seal the taboo on the dermatological subject.

* I am indebted to Dr. Paul O'Leary and his first assistant, Dr. Louis Brunsting of Rochester, Minnesota, for the opportunity of making the following observations, for many painstaking demonstrations, explanations and discussions, and for editorial review of this paper.

With such a predicament the psychiatrist, familiar with the misunderstandings which augment the sufferings of his own patients, can readily sympathize. Regarded frequently as malingerers, fakers, liars, and the like on the one hand, or as potential maniacs on the other, those troubled sufferers who have the intelligence and the opportunity to consult a psychiatrist are often rewarded by having the knowledge of this fact used by their friends as confirmation of a suspicion that they are of unsound mind and presumptively dangerous.

Dermatological and psychiatric patients have something else in common: their sufferings are vastly underestimated by those who have not experienced them. The torture to which some victims of eczema are subjected day after day and night after sleepless night for weeks, months and even years is a species of pain transcending that of far more dramatic afflictions. Only one who has observed these sufferers tossing and writhing in frantic anguish, or exhausted and desperate after a prolonged paroxysm of itching, can realize how far this exceeds the notion ordinarily connoted by the simple description of "itching." We are all familiar with mosquito bites and other minor itching experiences; and, as applied to someone else's sensations, the word seems to imply something trivial or ludicrous. The gross untruth of this easy but common assumption was one of the first startling realizations that came to me as an observer in the Dermatology Clinic.

Apart from the suffering involved, some dermatological lesions are so hideous or so situated—or both—that they can neither be exhibited nor casually described. I recall a case in which a destructive process had gradually eroded and destroyed most of the vulva and a part of the soft palate of a young woman who had been under treatment for four years! Dr. O'Leary informed me that the pain of these lesions is scarcely exceeded by that of an eroding carcinoma. The fact that her life was not threatened was hardly a source of comfort. Yet she could not easily explain or describe her affliction to friends and acquaintances. This is similar to the plight of most psychiatric patients, in contrast to that of most dermatological patients. The mentally ill have nothing to show the world, nothing to tell of their sufferings, that may not be met with skepticism or bewilderment. In general, the dermatological patient, whose "troubles" are exposed to the world, tries to assure others that he is not as sick as he looks, while the psychiatric patient who "appears perfectly well" tries to convince them that he is much sicker than he looks.

The average physician may assume, as did the author at one time, that dermatological practice is composed chiefly of distinguishing between syphilitic, psoriatic, parasitic, infectious, or other variegated lesions; fulgurating or x-raying facial blemishes, epitheliomata, verrucae, and the like; and occasionally diagnosing a rare skin disease to which a long Latin desig-

nation has been attached which no one but dermatologists can remember. By way of treatment, in the careless thinking of too many of us, the dermatologist is busy excising warts and applying salves.

No one should be more ready to sympathize with such depreciatory misconceptions of dermatology than the psychiatrist who is himself often conceived of as busily patting rich, hypochondriacal women on the back or fastening restraints about the wrists of violent psychotics. It is not my function to set the world straight on what the scientific dermatologist does and doesn't do. My present purpose is to present the concept of dermatological practice that I obtained in the course of my stay at Rochester, with particular reference to certain practical diagnostic and therapeutic problems in dermatology which seem to bear reference to psychiatry.

Patients come to the dermatologist with a great variety of lesions of the skin varying in size and number from one papule of pinpoint dimensions to a million papules, pustules, or blisters, or ten million itching, coalesced, scaling areas, anywhere on, or all over, the body. These lesions are occasionally painful; more frequently they cause itching; and still more frequently they are disturbing to the patient because they alter his appearance in a conspicuous and perplexing manner. The perplexity relates to the inexplicable origin of the lesions. Some patients elaborate fantastic reasons to account for their misfortune, but more commonly will say that they have simply "broken out." The mystery surrounding the origin of the lesions increases the patient's apprehensiveness in reference to the extent to which the lesion will enlarge or its possible malignancy. Added to this as already mentioned, is the variable degree of subjective sensory discomfort.

Empirically these lesions have been classified and given names by many different observers, some on the basis of pathology, some on the basis of morphology, and some on the basis of demonstrated or suspected etiology. Dermatological nosology is almost as confused as psychiatric nosology. But out of it can be organized certain large categories.

First, there appear to be certain *dermatological expressions of systemic diseases* such as measles, syphilis, and diabetes. Second, there are *neoplastic and infectious diseases* of the skin itself, such as lupus vulgaris, epitheliomata, and ringworm. Third, there are many more or less common *idiopathic syndromes* of which the etiology is unknown but of which the manifestations and course are well known, such as psoriasis and mycosis fungoides. Finally, there are the *reactive disorders* of the skin. These are caused by exposure to irritants, external or internal, and are often indistinguishable morphologically from the "eczema" to be discussed later. The detection and elimination of specific irritants is one of the most interesting fields of industrial medicine.

But in addition, the dermatologist sees many reactive skin disorders of more obscure nature. They are sometimes episodic, sometimes recurrent, and sometimes persistent. This group includes hives, diffuse urticarial rashes, and angioneurotic edema. The contribution of emotional factors to these conditions is a matter which the dermatologists have thought about from time to time, but from which they are constantly distracted by other theories of the moment. Skin tests, patch tests, passive transfer tests and the like are evolved and seem, for a time, to throw some light on the etiology and effective treatment of these conditions, even though it is apparent to the most superficial observer (and to the patient) that in many instances the symptoms are directly related to certain experiences and emotions. These cases have been studied by both dermatological and psychiatric colleagues, and their findings in specific cases have appeared with increasing frequency in the literature.*

But the great "plague" of dermatological practice is made up of a still more obscure type of reactive disorder, the eczema neurodermatitis family. It would seem as if in each specialty of medicine there is a sizeable group of patients suffering from conditions which are etiologically so obscure and therapeutically so refractory as to make them relatively "unwelcome" patients. Though they tax the skill and patience of the doctor, the results satisfy neither the doctor nor the patient. In the dermatological field the eczema family constitutes this plague.

There are large numbers of them, actually and relatively. Dr. O'Leary estimates that about a third of his case material falls into this group, and I understand that some dermatologists estimate the fraction even higher. These patients often suffer greatly, often find relief only after prolonged disability. At the Mayo Clinic they are frequently hospitalized, and their hospital care is more difficult and expensive than that of any other type of patient. The therapy applicable to them is far from standardized and often is ineffective. What relieves one patient makes another worse; sometime a half dozen different treatment applications have to be tried successively.

* I myself studied some of these cases at Rochester and I am somewhat conversant with the literature. I think it is conservative to say that the psychodynamics and personality characteristics of such cases are better understood than for any other type of dermatological lesion, but that the practical advantages of this information to the dermatologist are still rather slight. The more or less homespun psychotherapy of the dermatologist is often more efficacious than the more scientifically ordered psychotherapy of the psychiatrist for the simple reason that the latter is apt to conceive of a more radical and revolutionary change in the patient's personality structure. For a chronic, disfiguring psoriatic lesion, a patient may well consider a long time psychotherapeutic program worth the sacrifice; for an occasional urticaria most patients would not. Techniques such as hypnosis or narcosynthesis have not been consistently tried under research conditions.

The intractability of these cases and their tendency to recur lead the patient from doctor to doctor and from patent medicine to patent medicine. One of the Mayo Clinic stenographers remarked to me once that half the letters she was writing that day seemed to be answers to complaints that so-and-so "is still itching" or "is itching again." The reaction of such patients to their illness is often an unhealthy one; they become obsessed with the fear of recurrence or with disfigurement or with the intractability or with the arduousness of the treatment regimen. Their skin affliction becomes the most important topic in the home. Persistence of symptoms and conflicting medical opinion lead them and their families to become discouraged and depressed. (Curiously enough, these patients rarely become suicidal or psychotic.) In short, many of these patients are destined to chronic, intermittent, life-long suffering and have a physical handicap comparable to that of a man who has lost a leg or an arm—sometimes perhaps even greater.

For these reasons I was particularly interested in this eczematoid-atopic-neurodermatitic-lichen simplex group. Dermatologists have repeatedly called attention to the importance of the emotional factor in these cases, and some of them have gone to some pains to delineate the personality characteristics which seem to be common to many patients with these afflictions. (See especially Stokes, O'Leary, Becker.) A few psychiatrists—but very few—have written a little about it. The opportunity to see and talk with a good many of these patients in Rochester was an experience which had never come to me in my regular psychiatric practice, though I had seen many cases of urticaria, psoriasis, and factitious dermatitis. Details of my observations, and their correlation with reports by dermatologists and psychiatrists, will appear in a subsequent article.

The object of the present presentation is more general. I should like to go back to the comment with which I began this article. Psychiatrists come to depend very largely upon their ears; dermatologists upon their eyes. Psychiatrists spend long hours listening to the description of symptoms which no one can see; dermatologists concentrate upon examining lesions about which the comments of the patient are often not very helpful, or actually misleading.*

* One of my first impressions in Dr. O'Leary's clinic was the lightning speed with which a skilful dermatologist could arrive at a correct diagnosis by inspection. I recall a woman patient with a rapidly extending metastatic carcinoma of the skin of the chest. She also had a lump in the neck which she declared to be of ten years duration, dating from a period of acute tuberculous illness. I was considering the possibility that this lump in the neck was an irrelevant tuberculous lesion, of minor importance compared to the breast carcinoma. The dermatologist took a brief look and promptly disabused me of this notion. "What you see", he said, "is far more important than what you hear. The lump in the breast is carcinoma; the lump in the neck is also carcinoma, and it is not ten years old; it is recent. I think the biopsy

It would seem clear that dermatologists and psychiatrists should pool their skills in a cooperative effort. The great dependence of the dermatologist upon the discriminating observation which he has brought to such a high degree of perfection, has to a certain extent proved his undoing. No one is more aware of this than the thoughtful dermatologists themselves, because while it is true that correct diagnosis frequently leads with automatic celerity to proper treatment, it does not do so in the great burdensome eczematoid group. It is just here that the dermatologist becomes painfully aware of the fact that the diagnosis is the least of his troubles, and that an effort to understand more about the patient than is presented by the skin lesion is an essential to the proper management or cure or relief. The life history of the patient becomes more important than the lesion history. And this life history must be more than a series of dates and events; it must contain some indication of the patient's stresses and strains, his frustrations and fears, his anxieties and disappointments. Dermatologists are apt to feel insecure regarding their technique in obtaining such data; furthermore most of them are too rushed with routine procedures to devote the necessary time to it. Consequently while not a few dermatologists have been at some pains to point out that the problem exists, and even to offer thoughtful and documented discussions of their own observations and suggestions with reference to the problem, it remains for the most part a *terra incognita.* Certainly it has had the interest and attention of very few psychiatrists.

On the other hand, the psychiatrist who acts as a consultant or visitor in the dermatological clinic quickly learns that the techniques of his own routine practice are not capable of direct transfer to the dermatological problem. The patient with the skin lesion has oriented all of his thinking about that lesion, and it is exceedingly difficult for him to depart from this preoccupation. Furthermore, one is constantly aware of difficulty in limiting the biographical study for the psychiatric interview. By taking a detailed, circumstantial history of the present illness, one indeed learns that many things have happened in the patient's life which might be considered unusual emotional stresses. The question always is what role these stresses actually played with reference to current or previous skin eruptions. It is usually possible to discover the main trends of personality distortion; but

---

will confirm this." And it did. I remember several cases of the familiar dermatitis factitia type about which I have recorded some discussion elsewhere (*Man Against Himself*). What impressed me was the rapidity with which the dermatologist recognized the untruthfulness in the clinical history after he had taken one look at the lesion. To me these lesions were no more bizarre than numerous others which I saw. Particularly in one instance was I astounded at the courage of the dermatologist in promptly challenging the truth of the story given him by the patient. But he (the doctor) was entirely correct, and the patient admitted that the lesion was self-produced.

without the usual landmarks of psychiatric history taking and psychiatric personality description, it is difficult to interpret the findings in terms of the skin lesions. One feels sorely the need of those more objective devices for personality investigation, the projective tests of the clinical psychologist.

I came away from my visit to Rochester with a very strong feeling that a cooperative research program in this field should be set up along broad, and at the same time, intensive lines. It would seem to be desirable to congregate for cooperative effort a skilled dermatologist, a number of psychiatric history takers (who might well be recruited from highly trained social workers), a clinical psychologist trained in administering and interpreting psychological tests, and a psychiatrist capable of taking an over-all view of the data which would thus be obtained. The empirical findings of dermatologists in the *treatment* of the eczemas and the data of several psychoanalysts who by arrangement or by chance have had the opportunity of studying the unconscious psychological material of such cases, should also be studied.

From such a conjoint and cooperative research program the most valuable thing learned might not be the definition of certain peculiar dermatological personality types or even clues to the more efficacious treatment of these refractory cases. It might be the discovery of more basic information in regard to the function of the skin in the total personality structure. How basic and how important it is to understand this better may be inferred from the fact that the greatest sociological problem in the United States at this moment is one based on the single factor of skin pigmentation.

THE PSYCHOLOGICAL ASPECTS OF SKIN DISEASE

By ERIC D. WITTKOWER, M.D.*

I. Seborrhoeic Dermatitis†

Seborrhoea, a dysfunction of the sebaceous glands which without doing much harm may accompany an individual from the cradle to the grave, seems a condition par excellence likely to be personality bound. Dowling[4] and Ingram[8] draw attention to the high incidence of temperamental instability among seborrhoeics. "This may vary" states the latter, "from the sullen, sulky indolence of some of the heavier forms of acne to the highly-strung over-activity of the rosacea patient. States of anxiety, stress and strain are conditions which the seborrhoeic will not readily tolerate." Stokes and Sternberg stress the importance of emotional factors in seborrhoeic eczema of the ear, of the scalp and nape of the neck, of later life. However, no systematic approach to this problem has been made.

MATERIAL AND PROCEDURE

Biographical studies extending over about two hours in each case were made in an unselected sample of 100 seborrhoeic patients; the sample is composed as follows:

1. Diagnosis:
   - Seborrhoeic Dermatitis 85
   - Sycosis 15
2. Course of illness:
   - i. Onset
     - (a) Prior to Army Service 23
     - (b) Since enlistment 77
   - ii. Frequency of attacks
     - (a) First attack 60
     - (b) Previcus attacks 40
   - iii. Duration of illness
     - Up to 3 months 45
     - 4 months to 12 months 17
     - 1 to 3 years 16
     - Over 3 years plus ill-defined duration 22
3. Previous skin affections: (Boils, impetigo, unspecified skin affections) 30
4. Skin disorders in family 17

* London, England. Formerly Major Wittkower, R.A.M.C., now associated with the National Association for the Prevention of Tuberculosis, Tavistock House North, Tavistock Square, London, in a study of the psychological and sociological aspects of tuberculosis.

† This section is a condensation of an article of the same title by Dr. Wittkower published in *The British Journal of Dermatology and Syphilis*, July, 1947.

		Army Average* *percentages*
5. Rank:		
Officers	2	
W.O.s & N.C.O.s	23	20%
Ptes. or equivalent	75	80%
6. Type of enlistment:		
Reservists	5	2%
Territorials or Volunteers	29	38%
Conscripts	66	60%
7. Length of Service:		
Over 5½ years	5	24%
2–5½ years	69	60%
1–2 years	7	16%
Under 12 months	19	
8. Age: Varying from 18 to 43:		
Under 20	11	7%
20–30	59	46%
31 or over	30	47%
9. Marital Status:		
Married	56	55%
Single	44	45%
10. Intelligence:		
Within normal limits	†	89%
Mental defectives	†	11%

THE PERSONALITY OF THE SEBORRHOEIC PATIENT

A. Cross Section of the Sample Studied.

1. *On Examination:* Seborrhoeic patients because they were not easy talkers were not readily accessible to psychiatric approach. It usually required a good deal of encouragement and persuasion to draw them out. After they gained confidence they often revealed that they were rather nervous beforehand about being interviewed and they had always been afraid of persons in authority. Their hands were often clammy and they might blush if points were raised to which they attached personal significance.

2. *Social Relations:* Over two-thirds had always had difficulties in their social contacts. They were either shy, reserved and retiring or, less commonly, of a solitary nature. Fear of making themselves conspicuous and especially of being laughed at dominated their social behavior. With the support of a friend they were prepared to face a group of strangers but alone they felt lost, exposed, uneasy and tongue-tied. Apparently normal social relationships, if they did occur, were frequently based on a need to be on

* The term, "Army Average," refers to the army as a whole.

† It was not possible to have psychological tests made on any of the skin disease groups as such.

good terms with everybody and on an inability to create or to tolerate hostility toward themselves.

Because of their lack of self-assertiveness and overt aggressiveness they were easy to get on with, but their stubbornness made them awkward.

Men with these characteristics obviously were not ladies' men. Usually they managed to find a girl or two but were much too inhibited to embark on many amorous adventures which, in any case, would have been incompatible with their rigid moral views.

3. *Compulsive Urge to Work:* Most of the seborrhoeic subjects were hard workers; often they said, "the more work I have the more I like it." One of them had failed to apply for leave for two years and another worked from morning to night while on leave. If they had nothing to do they felt bored, tense and restless.

4. *Perfectionistic Trends:* Rules and regulations were their heart's delight and everything was carried out to the letter. Whatever they did they wanted to do as perfectly as possible no matter how much time it took or whether they had to start over again. If they were superiors they might become a nuisance by constantly checking to see if their orders had been carried out correctly.

5. *Feelings of Inferiority and of Inadequacy:* Their desire to work hard and the perfectionistic trends were prompted by feelings of inadequacy and fears of insecurity and punishment. They doubted their intelligence or knowledge or attributed their feelings to some real, grossly exaggerated or imagined physical defect. Typical of doubts of competence was the case of a sergeant-major with a distinguished war record who always "got into a complete flap" when there was an inspection. He had seen that everything was in perfect order and yet, perspiring profusely, he was lost for words when the distinguished visitor arrived.

6. *Doubts: Sensitiveness:* Because of uncertainty of themselves they required praise and encouragement. However well they carried out their duties, there was always doubt whether the accomplished task was to the liking of the person for whom it was done. Praise and acknowledgment stabilized their self-confidence for the time being but criticism disheartened them and threats frightened them disproportionately.

7. *Anxious Anticipation:* Related to their lack of self-confidence was commonly an anxious anticipation of misfortune. Many seborrhoeic patients stated that prior to tests or examinations they worried unduly. When the actual occasion arose they were self-composed and did much better than they expected. Generally they were apt to look at everything from the worst angle and to suspect danger where none existed. In civilian employment they expected to "get the sack" at any moment and on war service to be killed or to return mutilated, "and what would happen then

to my wife and family?" In conversation they were frequently deliberate and sometimes non-committal.

8. *Ambivalence:* More than usual, seborrhoeic patients were incapable of a true assessment of their feelings. For instance, against their own real interests, they might express self-sacrificing affection to one of their near relatives whom they had every reason to regard as cumbersome, and although there might be abundant circumstantial evidence in support of such an accusation, they would indignantly refute any suggestion of hostile feelings toward them.

9. *Aggressiveness:* Hardly any seborrhoeic in this series was pugnacious. They usually abhorred violence and tried to keep on good terms with everybody. Those in whom aggressiveness was little inhibited tended to be self-righteous. They might fluctuate between over-compliance and pigheadedness or be over-gentle in some respects and almost sadistic in others. Those who seemed completely inhibited in their aggressiveness sometimes had rare but violent outbursts of temper.

10. *Nervous Habits:* (a) Early: Thirty seborrhoeic patients had been nailbiters, 4 had picked their nails and 7 had speech defects as children. (b) Present: Of these, 23 were still nailbiters, three of the nailpickers still picked their nails; 3 men stammered badly, the other four slightly. Other nervous habits were uncommon.

11. *Gross Psychological Disorders:* Of the 100 men in this series 12 suffered from anxiety states (5 of them with somatic accompaniments, such as headache, palpitation, dizziness, dyspepsia, emotional diarrhea, diurnal enuresis). One man suffered from an obsessional state and one from epilepsy; two were schizoid psychopaths.

B. Longitudinal Section.

1. *Childhood:* Some of these seborrhoeics passed through an aggressive phase as children but most of them had always been meek, inoffensive and over-compliant. More than half of them (62 per cent) according to their accounts, were either spoiled or ill-treated as children or had grown up in an insecure environment. Whether they were spoiled or ill-treated they always longed for love and still more love; and if they did not get it they felt frustrated and resentful. Vague awareness of their own hostile impulses against those whom they loved, whom they ought to have loved, and, in any case, by whom they wanted to be loved, roused guilt and accounted for feelings of inferiority and sometimes almost furtive social behavior. They were constantly afraid of being found out and needed praise to be reassured this had not happened. They anticipated the worst because, incompletely recognized by themselves, they felt they did not deserve any better.

2. *School:* Seventeen patients of this series had had public school or sec-

ondary school education. Ten had obtained scholarships, 62 had reached top standard and 15 had been backward. Whether they had been bright or backward, they had tended to worry unduly about their lessons and examinations.

3. *Occupation:* Their work record was favorable. Eight of the men had changed their occupation four times or more and only three had not found permanent jobs before enlistment. Sixty-nine men had been in regular employment for 3 years or more up to the time of joining the Forces.

Sixty-seven per cent of this series could be classed as unusually conscientious workers. Only 6 per cent of the seborrhoeic patients had been careless in their civilian occupation.

4. *Married Life:* Owing to their highly developed sense of responsibility these seborrhoeic patients had tended to postpone matrimony until they were rather advanced in years and were less inclined than is usual to have children in wartime. Their feelings of inferiority predisposed them to jealousy while their high morality prevented them from acts of unfaithfulness. Generally their married life was happy. Marital discord was usually over money matters or an unfaithful wife.

5. *Army:* Thirty-four per cent served in the Territorial Army or joined as volunteers. They were ideally suited for routine duties although some had given rise to trouble by their insistence on carrying out their duties in their own way; others were slow in an endeavor to be accurate. If their social anxiety prevailed they kept away from their comrades; hardly ever were they the life and soul of the barrack room or of the mess.

A fair number refused promotion because of fear of responsibility. Those in whom aggressiveness was less inhibited made good non-commissioned officers. As such they were usually strict disciplinarians. They were particular about smartness and did not permit slipshod work. Although these seborrhoeic patients were predisposed to anxiety, a sense of duty usually kept them going in action; in situations demanding very severe responsibility, they were apt to break down.

LIFE SITUATION PREVIOUS TO ONSET

In 76 patients out of the total of 100, the onset of their skin trouble was preceded by some event which might have been upsetting to anybody. But the significance and possible aetiological relevance of these events could be fully appreciated only if the uniformity of the emotional repercussions, previous personalities and reactions to the disturbing events were taken into account.

Analysis of these events shows that they were of such a nature as to arouse anxiety (excessive responsibility), resentment (uncongenial Army employment), and shame (adultery or wife's unfaithfulness).

Almost without exception the incidents leading up to the onset of seborrhoeic dermatitis either affected the patients' social status or self-esteem. These are closely interrelated. Individuals delicately poised in self-esteem are obviously apt to react severely to any threat to or actual lowering of their social status. Conversely, any additional burden to a self-esteem already overladen with feelings of guilt is likely to lower the individual, in his opinion, in the eyes of the world. Viewed from the teleological angle, the advent of the skin affection would signify a self-imposed punishment, a camouflaged evasion of a dreaded situation or a violent protest against what was regarded as unfair treatment.

SOME ILLUSTRATIVE EXAMPLES

1. *Anxiety* (29 patients): Warrant Officer A., aged 30, had struggled against adversity throughout his life. His parents had been very poor. Before the war, after a hard uphill struggle, he had established himself in a fairly secure position as a wireman in an engineering depot. He joined the Territorial Army 12 years ago and was made a full bombardier when war broke out. In June, 1943, he was promoted a battery sergeant major. He was a man of few words and few friends. Though successful in the Army he had never been certain of himself. He always worried a great deal and problems of responsibility and security had always been very much on his mind. In 1941 his wife was living in Wales. The landlord wanted to evict her so he could sell the premises. The patient obtained leave to find another home but failed. On return to his unit he had his first attack of seborrhoeic dermatitis. In 1942 his wife was pregnant. During her pregnancy she became very seriously ill. Removal of the child was deemed necessary and several more operations had to be performed. He developed a second attack of seborrhoeic dermatitis. In 1944 he was in the bridgehead in Normandy. This was his first time in action. The job of a gun position officer was entrusted to him. After a fortnight he had to be withdrawn from the line because of a third attack of seborrhoeic dermatitis. At Christmas, 1944, he went on leave and found his wife had spent the money he had asked her to save, on drink. They had a serious row and upon returning to his unit he had his fourth attack.

2. *Resentment* (21 patients): Trooper C., aged 19, had always admired his father, "a man of great determination." But, unfortunately, his endeavor to emulate his father fell short of its aim. He managed to get into a Regiment of the Guards and was very proud of this achievement. He got on very well during basic training but failed dismally on armoured car training. After 5 weeks of trial he was transferred to the cookhouse. This was a severe blow to his pride. "I want to be a soldier. I tried so hard.

To put me on cooking is the last thing I thought they would do." While on the cooking course his seborrhoeic dermatitis commenced.

3. *Shame or Guilt* (26 patients): Signalman D., a 29-year-old Canadian, had obviously chosen the wrong woman as his wife. He married her in 1940 but soon found they were ill-suited. He came to England in 1942 and fell in love with a girl whom he wanted to marry. He asked for a divorce but his wife told him under no circumstances would she agree. After a while he and the girl became intimate. He was not the type of man to do this sort of thing light-heartedly. He believed in the sanctity of marriage and yet had only one desire—to escape from the shackles. After many months of campaigning overseas during which he worried a good deal about the unpleasant state of his private affairs, his unit was transferred to Holland and he was sent on leave to England. He went to his girl's home town and could have had a very happy time had he not developed seborrhoeic dermatitis.

REACTION TO ILLNESS

A man with running sores on his face painted with gentian violet, his hair shaven or his beard unshaven, does not present a very pleasant sight. People considerately inquire about his "bad face" and show by word or deed they are afraid of becoming infected. No wonder that most seborrhoeic patients are concerned about their unsightly appearance and the possibility of spreading the disease to other people ("Leper complex").

Forty cases in this series were only mildly embarrassed about their skin complaint whereas the remainder were seriously perturbed. Some men felt "that guilty about it" that they kept away from other people's company altogether. Others did not venture to go out during daytime; with their caps drawn over their faces and collars turned up they sneaked out when it was dark. The idea that other people might regard them as unclean or suspect them of V.D. was common. In addition, if their disease was prolonged, they were seriously concerned about the ultimate curability.

Apart from the severity of the skin affection, its localization and the length of illness, the emotional reaction to seborrhoeic dermatitis is obviously related to the previous personality. Men who had always been particular about their appearance and cleanliness were apt to react more severely than others. The malady also gave them a peg on which to hang their feelings of inferiority whereas their pessimistic outlook predisposed them to doubts of curability. Regarding the underlying conflict, the advent of seborrhoeic dermatitis affected them in two contrasting ways. It either gave them something else to worry about or, in their view, it demonstrated to the world—what they have long known—that they were "unclean."

POSSIBLE OBJECTIONS

1. The personality type described is very common and not specific for seborrhoeic dermatitis.

To meet this argument the series under investigation was compared with a control group of 50 war wounded examined for some other purpose.

	Seborrhoeic Dermatitis; percent	Control Group; percent
Grossly inhibited in social contacts	36	16
Unusually conscientious	67	24
Cannot relax	25	8
Worries unduly	40	26
Anxious	30	18

2. The psychological deviations found may be the result of the skin affection.

Great pains were taken in each case to reconstruct the personality previous to the onset of the skin complaint. This was impossible only in 7 patients who either continuously or with short symptom-free intervening periods had suffered from skin affections since early childhood.

3. Everybody has some worries or upsets.

This is true. But the emotional disturbances which in many cases preceded the onset of seborrhoeic dermatitis were severe, uniform and specific, i.e., of such a nature as to reactivate conflicts to which the patients had been previously sensitized. Moreover, the time relationship between disturbing events in the life history and the onset of the skin complaint was so close that the possibility of a mere coincidence could be safely excluded and little doubt was left as to the causal relationship.

DISCUSSION AND CONCLUSIONS

Seborrhoeic patients present what is commonly called an obsessional character. But, like many other psychologists, I believe that there are many shades of obsessional characters with varying emphasis on any one feature. Whereas the effort syndrome patient is predominantly concerned with problems of honor, morality and religiosity, the peptic ulcer patient preoccupied with bread and butter problems, the patient suffering from colitis with cleanliness and tidiness, difficulties in social contacts are the most prominent feature in seborrhoeics. It looks as if the seborrhoeic patient not only feels ostracized because of his skin affection but also is prone to develop his skin affection because he feels—and has always felt—ostracized. Whatever the psychological and physiological dynamics of the disorder may be, the malady disturbs his social relationships still further

and relegates him in many cases to the position of a pariah. Though outwardly protesting against this state of affairs and actually suffering through it, the seborrhoeic may inwardly accept the affliction as being well deserved.

To understand the pathology and physiology of the disorder offers no great difficulty. In animal experiments and in clinical experience—*e.g.*, encephalitis lethargica—evidence has been given regarding the nervous control of the sebaceous glands. It is conceivable that under nervous influences the composition of the sebum may be changed in such a way as to make it a suitable medium for otherwise harmless skin parasites.

However, without underrating the importance of emotional factors in the aetiology of seborrhoeic dermatitis, there is a danger in overrating them. Nevertheless, it still remains to be explained why only two-thirds of the patients studied conformed to the personality type described and why individuals of this type under the impact of disturbing events to which they had been sensitized develop this particular skin disorder and do not develop a nervous breakdown or any other psychosomatic affection. In answering these questions it must be assumed that in the aetiology of seborrhoeic dermatitis, multiple factors are at play and that a skin predisposition, possibly on a constitutional basis or perhaps as a result of previous skin infections, prepares the soil for its eventual outbreak.

The practical implications of the findings are obvious. In many cases of seborrhoeic dermatitis it seems safer to assess the prognosis of further military service and of an early return to duty or to civilian work on the basis of a personality and conflict assessment than on the basis of the presenting dermatological symptoms. Unless supplemented by adequate psychological care, local treatment alone is unlikely to safeguard against relapses. Welfare problems have to be dealt with in a certain number of cases. Choice of congenial employment is also essential in individuals so sensitive to injuries to their pride.

II. Psoriasis*

The aetiology of psoriasis is obscure. It is known that psoriasis is not infectious, that a tendency to develop it is hereditary in about 30 per cent of cases (Barber,[1] Roxburgh[16]) and that trauma sometimes determines the site of a patch. The "neuropathic hypothesis" goes back to Tilbury Fox,[7] Barduzzi[2] and Weyl.[18] Adherents of this theory found support in reports of some spectacular cases brought on by shock, grief or anxiety or in a coexistence of psoriasis with a variety of nervous symptoms (Eulenburg,[6] Bourdillon, Polotebnoff,[15] Kuznitzky,[10] Bunnemann[4] and many others). More recent converts to this hypothesis are Becker[3] and Obermayer. "We have noted," they say "in several instances a generalized flare-up of pre-

* Reprinted in a condensed form by permission from the *Lancet*, April 20, 1946.

existing eruptions of limited extent and the outbreak of generalized acute psoriasis after nervous or mild shock."

What follows is an exposition of findings obtained on psychiatric examination of a sample of 86 otherwise unselected military patients suffering from psoriasis. Biographical studies extending over two hours were made in each case.

MATERIAL AND PROCEDURE OF EXAMINATION

1. Sex: Male 74: Female 12.
2. Course of illness when interviewed: Acute: 17: Chronic 69.
   - i. Onset
     - (a) Prior to Service 56
     - (b) Since enlistment 30
   - ii. Frequency of attacks
     - (a) First attack at time of examination 16
     - (b) Previous attacks 23
     - (c) Continuous 47
   - iii. Duration of illness
     - (a) From early childhood either continuous or with free periods 14
     - (b) For 6 years duration or more 40
     - (c) Recent (i.e., within the last 5 years, plus relapses) 32
3. History of psoriasis in the family (parents or siblings) 24

			Army Average
4. Rank:			
W.O.s and N.C.O.s	23%	(20)	20%
Privates or equivalent	77%	(66)	80%
5. Type of Enlistment:			
Reservists, Regulars	1%	(1)	2%
Territorials and Volunteers	40%	(34)	38%
Conscripts	59%	(41)	60%
6. Length of Service:			
Over 5½ years	12%	(10)	24%*
2–5½ years	60%	(52)	60%
1–2 years / Under 12 months	28%	(24)	16%
7. Age on examination:			
Varying from 18 to 44.			
Under 20	16%	(14)	7%*
20–30	46%	(40)	46%
31 or over	38%	(32)	47%
8. Marital Status:			
Married	49%	(42)	55%
Single	51%	(44)	45%

9. Intelligence:
   - Within normal limits 82
   - Mental defectives 4

* The difference between the sample and the Army average is probably due to the fact that early intakes suffering from psoriasis report sick more readily than soldiers who have been in the Army a long time.

FINDINGS

In 14 of the 86 patients examined, psoriasis started in early childhood (early childhood group) and no assessment of their personality prior to the time of onset of the psoriasis could therefore be made. Of the remaining 72 patients whose previous personality could be made out with reasonable accuracy, 29 patients were classed as either emotionally well—or fairly well-adjusted (well-adjusted group). Twenty-nine other patients showed definite personality deviations prior to the onset of the skin affection, and 14 were psychiatrically ill at the time of its onset (maladjusted group). Of those described as psychiatrically ill, 8 suffered from anxiety states, 3 from hysteria, 1 from reactive depression and 2 were psychopathic personalities, one with emotional abnormality and one with antisocial trends. The following description of personality types is based on the 43 patients of the maladjusted group.

A. Previous Personality.

1. *Compulsive Type* (11 patients): Individuals of this type unreasonably expended their energy on work. Originally spurred on by fear of a threatening and punishing father or by desire to please an over-ambitious mother, they became afterward self-propelled. They went to an enormous amount of trouble to achieve perfection at work but they always doubted its correctness however carefully it had been done or checked. They liked to carry out their work in their own way and in their own time; if they were rushed or overburdened with work they were apt to lose their heads. Uncertain of themselves, they reacted disproportionately to failures and reverses, to rebuffs and to criticism. Because restricting authority had become part of themselves, their hate of it was of necessity greatly self-directed.

2. *Overaggressive and Unaggressive Types* (14 patients): Overaggressive: The 3 men in this subdivision were characterized by their refractory and obstreperous behavior. Instead of accepting parental dictates, like the members of group 1, they rebelled against it and continued to kick against authority in later life.

Unaggressive: These individuals had never been able to hold their own in arguments or fights. As soldiers they dreaded going into action and did badly if they had to go. They were preoccupied with killing, death, mutilation and the futility of warfare. In their social relationships they were governed by an endeavor to be on good terms with everybody and to be well liked. Consequently, they were quiet, conciliatory and over-obliging. Intense feelings of inferiority were a prominent feature in 3 of these patients.

Ambivalent: Some of the patients were more than usually double-edged

in their attitude toward near relatives, *i.e.*, they displayed feelings of self-sacrificing affection to members of their family whom they actually hated.

3. *Bisexual Type* (8 patients): Five members of this group were male and 3 female. With one exception they were offsprings of unhappy families. All of them rejected the parent of their own sex, usually because of his or her vile temper, and adored the parent of the opposite sex with whom they identified themselves to an unusual degree. As a result the male patients became effeminate and the female patients masculine. Four clearly realized they harbored two different personalities whereas the others were unaware of their psychological difficulties.

4. *Phobic Type* (7 patients): Phobias arising from similar psychological sources were a prominent feature in some individuals. Included in this group were 3 men who suffered from anxiety symptoms of a phobic nature subsequent to serious accidents.

5. *Hysterical Type* (3 patients): In 3 men of this series, hysterical characteristics or symptoms preceded the onset of psoriasis.

B. Life Situation at Onset.

Of the 72 patients whose previous personality could be made out with reasonable accuracy, emotional factors played a relevant part in the aetiology of the disorder probably in 29 and possibly in 20 others. No such evidence could be found in the remainder. Relevance was regarded as "probable" when events preceding the onset of the disorder stirred up emotional conflicts to which the individual had been specifically sensitized and as "possible" when the onset occurred during periods of emotional tension not immediately related to problems and conflicts specific for the personality affected.

Emotional Factors Operative In Aetiology

PERSONALITY	TOTAL	PROBABLY	POSSIBLY	NO EVIDENCE
Well or fairly-well adjusted.....	29	1	6	22
Maladjusted or psychiatrically ill.....	43	28	14	1

The table shows that an aetiological connection between the emotional maladjustment and the onset of the psoriasis could not be established in every case of the maladjusted group, whereas in some patients classed as previously well-adjusted, emotional factors apparently played a relevant part in the aetiology.

The following examples illustrate the mode of onset in relation to the previous personality. They were selected from the groups of cases in

whom evidence for aetiological relevance was regarded as probable and are arranged according to the personality types described above.

1. *Compulsive Type:* L/Bdr. G., aged 30, was a little man. On examination he dictated—in both senses of the word—rather than spoke about himself in a free and easy manner. In doing so he got lost in minute, irrelevant details. He was dead serious and could not be made to smile. The keynote of his life had always been work. Originally he was driven by his nagging father, afterward by his severe conscience. His aim had always been security, early retirement and leisure. But somehow, however hard he had tried, he had never been capable of relaxation. If he were left alone, he seemed an extremely competent worker, but if he had to work in a hurry or if a superior were present he became flustered. If he did not feel himself equal to a task he would lose his head altogether. "When I was 21, I took on a job as accountant for 3 companies and felt that because of my age this was too much for me. About a week after the psoriasis started; however, I persevered and was determined that I should not let the job beat me. In 6 weeks the psoriasis cleared. The reason why it cleared was that I settled down to the job and it did not worry me any more. After that I was only troubled with a very small patch when I had exceptional worries. When I came into the Army I was worried about being regimented and everything I had to do." He had a severe relapse three to four weeks after his enlistment.

2. *Overaggressive and Unaggressive Types:* Overaggressive: Private H., aged 22, had always been up in arms against authority. He was the son of a man previously in a position of authority, an unfortunate individual who tried to educate his children by deriding their unsuccessful efforts. As a child the patient was self-willed and unmanageable; afterward, in contact with superiors, he was either frankly stubborn and argumentative or terrified. Boxing was his favorite hobby. He joined the Army five months ago. Following his enlistment he developed marked anxiety symptoms. His psoriasis began within 3 months.

Unaggressive: Private I., aged 32, a woman refined in caste and sensitive in nature, had not known that she was of illegitimate birth until she was 16. The foster mother was possessive and domineering. The patient always craved affection but, partly owing to her foster mother's attitude and partly as a result of her self-imposed isolation, she had never been able to obtain it. When she was 16 her foster mother revealed the secret of her birth. This revelation greatly intensified the patient's feelings of inferiority. She then had a nervous breakdown during which she developed the first symptoms of psoriasis. Since then she has had 3 relapses, one when her foster mother had a stroke; the second, when against her foster mother's wishes, the patient, with with severe pangs of conscience, volunteered for the A.T.S.; and the third, when her application for a compassionate home posting, made under pressure by her foster mother, had been granted.

Ambivalent: Private K., aged 19, had always been intensely ambitious. Although he and his brother were inseparable and to all appearances the best of friends, there was a rivalry of a somewhat vicious nature between them. When the patient was 12 years old his brother sustained an accidental head injury. "I was very upset when he had to go to the hospital and during that time I was rather jumpy and when I heard that he was dead, I was ill. After a short time elapsed, I found that the skin trouble was breaking out on me."

3. *Bisexual Type:* Private L., aged 29, was the daughter of a time-serving soldier. She had always greatly admired her father. Talking about her mother she dismissed her as "a talkative, scatterbrained child married to a grown-up silent man." The pa-

tient was masculine in appearance. Her voice was low pitched and her speech more that of an old soldier than a member of the fair sex. She used make-up and as the conversation drew on displayed a certain amount of feminine charm. She was a clear and logical thinker and had a remarkable insight into her emotional difficulties. There were two totally different personalities in herself, one masculine and the other feminine. The patient watched these two personalities like an unconcerned observer. The masculine side was a soldier—like her father, hard and harsh. The feminine side longed for affection—alas in vain—and delighted in feminine pursuits. She had always been a woman hater and was sexually frigid.

At the age of 18 she chose to become a nurse in a Children's Hospital. The work was strenuous but, more important than this, to work in a female community proved irritating to her. Soon afterward she developed a patch of psoriasis which regularly disappeared when she went on a holiday and came back each time when she returned to duty. Eventually after 2 years she gave up this job and was free from psoriasis until in 1941 when she volunteered for the Army. Enlistment presented an emotional strain to her on three counts: life in a female community did not agree with her, she "wanted to be a soldier and not an A.T.S. girl" and thirdly, her aspiration to become an officer was not fulfilled.

4. *Phobic Type:* Spr. M., aged 35, appeared tense, anxious and puzzled. His mother died when he was 5 years old. At the age of 8, roughly coinciding with his father's second marriage, he had a nervous breakdown. His stepmother was a brutal woman, dirty in her habits. Before his recent breakdown he was a quiet, solitary individual, very conscientious at work and prone to worry unduly. He had always been unusually fussy about cleanliness and had a morbid fear of infection and enclosed spaces. In February, 1943, he was taken prisoner. To live behind barbed wire was unbearable for him. In what obviously amounted to a phobic panic he escaped from the camp. He then joined Italian partisans and lived with them for 16 months under conditions of great hardships. His psoriasis started in the prison camp.

5. *Hysterical Type:* Gnr. N., aged 19, was not much of a soldier. He had only been 12 months in the Army and had hankered all the time for his mother's loving care. He was the only child and had been doted on by both his parents. In his home village he was a lone wolf spending most of his spare time in his mother's company. In talking about her he cried bitterly. His enlistment was a severe blow for the whole family. But to go overseas was definitely too much for him. His embarkation leave was a sad and tearful affair. On return to his unit he was covered with spots and had to be taken off the draft.

C. Other Aetiological Factors.

1. *Heredity:* Twenty-four of the patients reported that other members of the family suffered from psoriasis: One in two of the early childhood group, one in three of the well-adjusted group and one in six of the maladjusted group showed a hereditary predisposition to psoriasis. A similar trend is noticeable regarding age of onset. Evidence of hereditary predisposition was found in one in two up to the age of ten, in one in four between the ages of eleven and twenty, and in one in six over the age of twenty.

2. *Febrile Diseases:* Psoriasis developed in 6 patients in the course of, or subsequent to, a febrile disease.

3. *Trauma:* Three patients had their first attacks of psoriasis after a serious accident, two after an appendix operation and one after an operation for varicose veins (at the site of the operation). Three patients had been scalded in childhood.

D. Reaction to Illness.

The social effect of a skin condition, such as psoriasis, is considerable. To the layman's mind it conjures up V.D., dirt and neglect. Hence, the psoriatic soldier, whenever communal life in the Army necessitated undressing in front of others, expected to be gazed at or asked awkward questions. Marital discord over psoriasis arose over such varying causes as flakes on the carpet, bedclothes stained with ointment and sexual refusal by a wife frightened of infection. If his hands were affected, his dancing partner might comment on it, and if he had eruptions on his head the barber might refuse to cut his hair. No wonder, therefore, that most psoriasis patients are seriously concerned about their skin complaint. Gradually they cut themselves off from all sports activities and, in extreme cases, from social activities altogether.

If this were their first attack they might still hope for improvement, but if they have suffered previously, it may dawn upon them that they will have it always. They then begin to worry about how it will affect their civilian occupation and whether "with that" they will ever find a wife. If they are married they wonder whether they will pass it on to their children.

Cases of very long standing deserve special interest as regards their reaction to illness. Eleven of the fourteen patients of the early childhood group made a fairly good adjustment; three, in apparent relation to their long-lasting skin affection, developed a peculiar schizoid picture with shut-inness, extreme shyness in social contacts, and paranoid formation as prominent features, and an inability to express their thoughts and feelings.

DISCUSSION AND CONCLUSIONS

Psoriasis is a disease not physically or mentally bound to any one personality type. The number of emotionally maladjusted individuals in the 86 examined was far in excess of a cross section of the population or a random sample of soldiers.

It is fascinating to speculate—to borrow a phrase from Halliday—on why patients suffering from psoriasis fall ill in the way they do, *i.e.*, to attempt to understand the psychological meaning of their complaint. But there is no uniformity of emotional conflict. In the light of our present knowledge one can state only that individuals in whom the hereditary element is very powerful may develop psoriasis in any case whereas others need a catalyst to mobilize a dormant predisposition. More often than is

generally known, emotional crises of a nature specific to the individual seem to assume this function. In other words, if an individual is emotionally maladjusted for reasons unrelated to the psoriasis, the emotional maladjustment may—but need not—take charge of the psoriasis and may determine its onset and further relapses. The parallel to other conditions such as allergic manifestations and *diabetes mellitus* is obvious.

III. Pompholyx*

Pompholyx was considered as a neurosis by Tilbury Fox[7] who first described it in 1873. Since then it has been the subject of much study. More recently the original idea that pompholyx is a psychosomatic disorder has gained ground. Patients suffering from pompholyx, according to Lehmann,[11] "are usually nervous, under pressure of duty or responsibility or are debilitated." Some writers commit themselves still further. Mackenna[12, 13] was the first to suggest a definite psychological meaning underlying the skin disorder. "A patient suffering from pompholyx," he says, "may be indicating by a psychological mechanism that he cannot use his hands or feet; if he is a soldier, despite the protests of his conscious mind, he may be dumbly stating the violent belief of his subconscious." A few patients suffering from pompholyx have been submitted to psychiatric scrutiny (Pearson[14]) but no systematic approach to this problem has hitherto been made.

MATERIAL AND PROCEDURE

An otherwise unselected sample of 50 military patients suffering from pompholyx was psychiatrically examined. The interview covering the patient's clinical and life histories lasted about two hours.

1. Sex: Male 43: Female 7.			
2. Course of illness when interviewed:			
Onset (a) Prior to enlistment	10		
(b) Since enlistment	40		
3. Rank:			Army Average
Officers	2	(4%)	
W.O.s & N.C.O.s	14	(28%)	20%
Ptes. & equivalent	34	(68%)	80%
4. Type of Enlistment:			
Regulars	4	(8%)	2%
Territorials & Vols	13	(26%)	38%
Conscripts	33	(66%)	60%
5. Age on examination: *Varying from 18 to 44.*			
Under 20	6	(12%)	7%

*This section and the two preceding ones were condensed from the original manuscript by Dr. Irving Baer, Fellow of the Menninger Foundation School of Psychiatry.

20 to 30	17	(34%)	46%
31 or over	27	(54%)	47%
6. Marital Status:			
Married	35	(70%)	55%
Single	15	(30%)	45%
7. Intelligence:			
Within normal limits			45
Mental defectives			5

FINDINGS

A. Previous Personality.

Four-fifths of the patients were emotionally maladjusted or actually psychiatrically ill prior to or at the time of the onset of their skin complaint. Of those psychiatrically ill, four suffered from acute and five from chronic anxiety states; one from a reactive depression. Those classed as emotionally maladjusted were about evenly distributed between individuals with predominantly hysterical and predominantly obsessional characteristics. Thirty of the fifty patients presented one or several of the following symptoms: persistent headaches, chronic indigestion, cardiac pain, fatiguability, fainting fits, trembling fits, crying fits, sleep-walking, sleeplessness, restlessness, obsessional fears, obsessional doubts, compulsions. In addition, three men obviously made the most of minor physical handicaps. The remaining ten patients were emotionally well adjusted.

According to their prevailing characteristics, the 40 patients classed as emotionally maladjusted or psychiatrically ill, could be grouped as follows:

1. *Vain and Conceited* (6 patients): Individuals of this type were often affected in their manners and in speech. They had no doubt of their outstanding abilities and good looks. If they were males they boasted of easy successes with women and, if females, of their host of admirers. Their freely displayed emotions were shallow. Depth of feeling was also lacking in their personal relationships; they were much too fond of themselves to be really fond of anybody else. Demands which entailed discomfort, such as to endure the inevitable hardships of Army life or even to be enlisted called forth childish resentment.

2. *Ambitious: Afraid of Failure* (10 patients): Similar in a way and yet basically different were those whose vanity centered about their accomplishments. Their aim was success, and with this end in view they worked hard and untiringly. To achieve self-advancement they were willing to pay a heavy price, if necessary, at the expense of others. They might reach their objective but even if they did they were never satisfied. They were constantly harassed by feelings of inferiority and inadequacy which alternated with a gross overrating of self-importance. Like the previous group, but for different reasons, they stood up badly to frustration.

3. *Afraid of Getting Hurt* (6 patients): Browbeaten or spoiled as children, they had never been able to fight their own battles; even as grown-ups they tended to cling to their mothers' apron strings. Because they were unable to hold their own, men of this type were usually the butt of their comrades; under battle conditions they were useless. Their fear of getting hurt might assume quite grotesque proportions.

4. *Afraid of Showing Fear* (6 patients): These were individuals characterized by a severe sense of duty and of responsibility which compelled them, in contrast to the previous group, to carry on unflinchingly in the face of danger however scared they were. Any display of emotion, in general, was incompatible with their self-respect.

5. *Afraid of Own Impulses* (12 patients): Whether predominantly hysterical or predominantly obsessional, individuals grouped under this heading struggled against impulses—sexual or aggressive—which they were unable to tolerate. These impulses might be conscious (as phantasies) in the former and revealed themselves in an inverted form in the activities of the latter. A young woman, hysterical in type, for instance, indulged in phantasies of torturing and killing whereas a man of obsessional type, though inwardly itching to assert himself, took absurd care not to inconvenience others.

B. Life Situation at Onset.

Comparison of carefully dated life histories with dated clinical histories showed that in 33 of the 50 patients examined the onset of their skin affection was preceded by emotional disturbances which, arising from without or from within, were of a specific nature. This, therefore, justified an assumption that these disturbances had precipitated the onset of the complaint. Events leading up to development of pompholyx consisted of blows to vanity in group 1 (vain and conceited), frustration of ambition in group 2 (ambitious, afraid of failure), and exposure to hardships and dangers in groups 3 and 4 (afraid of getting hurt and afraid of showing fear, respectively). Accumulation of guilt over forbidden impulses or over putting them into effect seemed to be the operative precipitating factor in group 5 (afraid of own impulses). Varying according to whether the hands or the feet were affected, a definite purpose in developing the skin complaint was clearly recognizable.

1. *Vain and Conceited:* Sgt. O., aged 35, had no doubt of his outstanding abilities. "I am gifted with a ready flow of language," he said. "I presume people like to hear me talk." He was one of those people who took the lead wherever he went, who suggested something even if there was nothing to suggest, who was only really happy if he dominated the stage and was surrounded by a crowd of admirers. He admitted that his enthusiasm sometimes carried him too far and described himself as highly strung, sensitive to beauty, and imaginative. Before marriage he had a large number

of flirtations. After one of them, two years before, which had a rather unhappy ending, he developed periodic headaches which proved intractable. When he was de-reserved he joined the Army with mixed feelings. He soon found the infantry training "very fatiguing" and fell out repeatedly. Within the first week of infantry training he developed podopompholyx which became worse as the training advanced, so that he had to be transferred to another corps.

2. *Ambitious: Afraid of Failure:* Pte. P., aged 39, was a man of humble origin. At the age of 15 he started to work as an office boy and worked up to the position of a transport executive. A self-made man, he had every reason to be proud of his accomplishments, but success went to his head and he became vain, conceited and supercilious. He did very well in the Army but not well enough for his liking. His one and only ambition was to become commissioned. He achieved this in May, 1943, but broke a leg going over an assault course. Because the fracture did not heal satisfactorily he could not accept the commission and had to be employed in a sedentary occupation as a private. In addition, he had word that his good-looking wife had run away with somebody else. Two severe slights in short succession were too much for him. He withdrew from all social activities and developed podopompholyx.

3. *Afraid of Getting Hurt:* Pte. Q., aged 39, looked like a frightened rabbit. He had always been of a timid nature and had never been in a fight in his life. He became very excited during arguments but backed out as soon as they got heated. To leave his "missus" on enlistment was a hard blow for him. During his three and a half years of service, according to him, he was a "washout" all along. He repeatedly reported sick because of a slight hernia and eventually was sent to a psychiatrist. The patient informed the psychiatrist, he could under no circumstances go overseas in view of his hernia. When shortly afterward he was sent on embarkation leave, he developed podopompholyx and had to be taken off the draft.

4. *Afraid of Showing Fear:* Cpl. R., aged 26, British by birth, had been brought up in one of the South American states. He was a quiet, unassuming, extremely conscientious young man. Shortly after his enlistment he had what he called a small accident. During a demonstration an explosive went off. The patient was blinded for a fortnight and another man had one hand blown off. This incident, according to the patient, left him unperturbed. In February, 1942, he had another accident, in which a lorry overturned. He sustained severe injuries and was in the hospital 6 months. After discharge from the hospital he was afraid of going by lorry and generally nervous of traffic but carried on as usual. During this time he noticed the first mild symptoms of the skin complaint. Just before the invasion of the continent his feet and hands became very much worse. In France he was employed in a perilous job in front of the advancing infantry. Though by now suffering from a fully fledged anxiety state he "stuck" it until a further aggravation of his skin complaint made his evacuation to England necessary.

5. *Afraid of Own Impulses:* Pte. T., aged 23, a regimental policewoman, gave the impression of a self-assured, self-possessed, prim person accustomed to making her own decisions and to act accordingly. She was a strict vegetarian, drank very little and carried out her duties to the letter. Since her childhood days she had never shed a tear. She felt more at home with men than women, but she had never been in love with any man. In fact, except for her mother whom she adored, she had never loved anybody in her life. In July, 1944, her mother was suddenly paralyzed. A doctor was called and told the patient the only hope was to take her mother to a hospital. Her mother had always been afraid of hospitals. "I persuaded her to go into the hospital. Two days before she died she began to scream and said it was my fault that

she was dying because I had put her into a hospital. She tried to get up and I tried to hold her down." A few days after the death of her mother the hand which had held her mother came up in blisters.

DISCUSSION AND CONCLUSIONS

Psychiatric examination of 50 patients suffering from pompholyx revealed that a majority of them had been emotionally maladjusted long antedating the onset of their skin disorder. Among those classed as emotionally maladjusted, individuals with predominantly hysterical and predominantly obsessional characteristics were about evenly distributed. Excessive self-love (narcissism) was a common feature in those predisposed to pompholyx. Fifteen out of the 50 patients studied suffered previously or simultaneously from psychosomatic affections such as intractable headaches, nervous dyspepsia and bedwetting (in adult life).

The evidence accumulated strongly suggested that pompholyx viewed in terms of psychodynamics serves a definite purpose. In a manner so familiar in hysterical conditions it is used as a means of evasion (in groups 1 to 4) and as a means of self-punishment in group 5. In the peculiar and yet so eloquent body language, pompholyx seems to convey that an individual wishes to "throw in" his hands or is unwilling to use his feet (groups 1 and 4) whereas, in the case of group 5, it seems to signify an urge to confess and a desire to atone.

If this language is well understood, a good deal can be done to relieve the complaint by environmental manipulation or by welfare measures. Moreover, in view of its hysterical origin, pompholyx is likely to be easily amenable to short psychotherapy.

REFERENCES

1. Barber, H. W.: Discussion on the Skin Manifestations in Rheumatism. *Proceedings of the Royal Society of Medicine*, 31:701, 1938.
2. Barduzzi, D.: Quoted from H. G. Brooke. Psoriasis. *System of Medicine*. London, Allbutt and Rolleston, 1911, Volume 9, p. 357.
3. Becker, S. W. and Obermayer, M. E.: *Modern Dermatology and Syphilology*. Philadelphia, Lippincott, 1940.
4. Bunnemann, O.: Neue Beiträge zur Frage der Psychogenese von Hautsymptomen. *Zeitschr j. d. ges. Neurologie und Psychiatrie*, 88:589-600, 1924.
5. Dowling, G. B.: The Aetiology of Seborrhoeic Dermatitis. *British Journal of Dermatology and Syphilis*, 51:1-13, January 1939.
6. Eulenburg, A.: Lehrbuch der Nervenkrankheiten. *Störungen der Ernährung (Trophoneurosen)*. Berlin, A. Hirschwald, 1878, Part I, p. 332, iii.
7. Fox, Tilbury W.: *Skin Diseases*. London, H. Renshaw, 1873, p. 264.
8. Ingram, J. T.: The Seborrhoeic Diathesis. *British Medical Journal*, 2:5-8, 1939.
9. Klaber, R. and Wittkower, E.: The Pathogenesis of Rosacea. A review with special reference to emotional factors. *The British Journal of Dermatology and Syphilis*, 51:501-524, December 1939.

10. KUZNITZKY, M.: Aetiologie und Pathogenese der Psoriasis. *Archiv für Dermatologie und Syphilis*, 38:405–460, 1897.
11. LEHMANN, C. F.: Acute Vesicular Eruptions of the Hands and Feet. *Archives of Dermatology and Syphilology*, 21:449–463, 1930.
12. MACKENNA, R. M. B.: Psychosomatic Factors in Cutaneous Disease. *Lancet*, 2:679–681, 1944.
13. MACKENNA, R. W. AND R. M. B.: *Diseases of the Skin*. London, Bailliére, 1937.
14. PEARSON, G. H. I.: Some Psychological Aspects of Inflammatory Skin Lesions. *Psychosomatic Medicine*, 2:22–33, 1940.
15. POLOTEBNOFF, A. G.: Psoriasis. *Dermatologische Studien*, Fünftes Heft, pp. 39–142, 1891.
16. ROXBURGH, A. C.: *Common Skin Diseases*. 7th edition. London, H. K. Lewis, 1944.
17. STOKES, J. H. AND STERNBERG, T. H.: A Factor Analysis of the Acne Complex with Therapeutic Comment. *Archives of Dermatology and Syphilology*, 40:345–367, September 1939.
18. WEYL, A.: Anomalien der Epidermis. *Ziemssen's Handbuch d. speziellen Pathologie und Therapie*. Leipzig, F. C. W. Vogel, 1883, Volume 14, Part 2, p. 501.
19. WITTKOWER, E.: Psychological Aspects of Dermatology. In R. M. B. MacKenna's *Modern Trends in Dermatology*. London, Butterworth & Co., 1947 (at press).

PSYCHOANALYTIC OBSERVATIONS ON SKIN DISORDERS*

By BELA MITTELMANN M.D.†

In experiments and in psychoanalytic interviews Mittelmann and Wolff[1,2] have observed that skin temperature of the fingers was relatively high when the subjects felt secure and were relaxed. The finger temperature dropped (vasoconstriction) during stress reactions characterized by anxiety, depression, anger and guilt. The finger temperature rose above relaxation level (vasodilation) during sexual excitement. The skin temperature of the face rose under both types of circumstance. In general, feelings of comfortable warmth implied, psychologically, security, love and care; cold implied rejection, loneliness and being abandoned; feeling of uncomfortable heat implied embarrassment and shame over sexual excitement.

Saul and Bernstein[3] observed the circumstances and emotional setting under which urticarial attacks occurred in a young married woman. Their patient suffered from chronic urticaria but the sequence of reactions leading to recurrent attacks during the analytic treatment was clear: longings for love; then wishes to satisfy these through sexual love; frustration of these wishes due to fears of sex; then increased tension, finally increased allergic sensitivities as a result. Weeping bore a special reciprocal relationship to the urticarial attack. When she repressed her weeping she developed urticaria and attacks usually terminated with weeping.

Deutch[4] observed that in a young married woman with paranoid trends the verbalization of the emerging hateful thoughts against her mother was always preceded or accompanied by a furious and desperate attack of scratching her scalp, arms, or other parts of her body. The hateful resentments finally led to the recollection of the prohibition of her infantile masturbation. Another patient, a 25 year old unmarried girl, had a sensation during an analytic hour almost as if she were stung on her arm. She became very apprehensive. Then she recalled a memory of her early childhood in which her father had played "bumble bee" with her. Another patient, a girl in her early thirties, with paranoid trends, used perceptions of temperature variations of the skin as precursory symptoms of the emerging unconscious trends. She complained of chills when, in the analysis, she worked out her detachment from her father, and of feverish feeling when her sexual attraction to her own sex was revealed. With her tendency

* Read before the annual meeting of the American Psychoanalytic Association in New York, May 18, 1947.

† Cornell University Medical College, New York Hospital, New York.

to projection she usually complained that the room was too hot or too cold when she entered the office.

The author has observed three patients with skin disorders appearing in the course of the analysis. Of these three one will be reported here in detail. The other two will form the basis of another paper.

Case Report

A patient with active, aggressive, out-going personality—suffering from arterial hypertension and later, from periods of psychoneurotic depression and anxiety—had had attacks of itching, dermatitis, and angioneurotic edema in the past, with recurrence of dermatitis and edema when she decided to separate from her husband.

A 51-year-old married woman suffered from arterial hypertension (200/-110), of four years' duration, with secondary recurrent heart failure which was kept in check most of the time through the oral administration of digitalis and intramuscular injections of mercuhydrine. She entered analytic treatment on the advice of her physician, who found her tense and difficult to manage. However, she disputed every interpretation of the analyst's, could not tolerate ever being in the wrong, and after six weeks terminated the treatment. Four years later, she returned for treatment in a depressed state, feeling cornered and at a loss as to what to do with herself, with her life, and with her husband. She wept during the interviews, and urgently asked for help. She was now able to accept interpretations and remained in treatment for a year and a half.

The patient was the oldest of three girls. Her next sister was four, the other sister eleven, years younger than the patient. She had manifested sharp rivalry toward the sister next to her as far back as she could remember, calling her stupid and unattractive, and tried to rule her constantly. The sister never could fight back. The patient considered her father unimportant although her relationship with him was friendly. He died when the patient was 34. She was never close to her mother, felt that her mother was blind in objecting to the patient's "mistreatment" of her sister, and unconsciously resented, yet also longed for, her mother's over-solicitousness about health, dietary and excretory habits. She never contradicted her mother until she entered college. Gradually the relationship became overtly bad until they could not spend a day together without serious clashes occurring.

She had known her husband since she was 13. At the age of 22 she expected to marry another man whom she loved and respected and with whom she was physically intimate except for actual sexual intercourse. After this man withdrew from courtship, she became depressed for several

months and then married her present husband who had kept up a courtship all the while. Simultaneously, the patient's rival sister married the husband's brother. The patient always considered herself superior to her husband. She was very active in organizational work for various civic and religious institutions, attending meetings, organizing committees, participating in heated debates, and being elected to high offices. She ran the household adequately at the same time and also dominated her husband, who, however, retained his business activities as an area for himself about which he told his wife nothing. In discussions with her, he never gave in and never ackowledged that she was right but just stopped talking. She had two children whom she dominated.

She denied ever having masturbated. She was capable of clitoral and vaginal orgasm but usually had more frequent desire for intercourse than her husband. She had always had a strong need for physical closeness. In this, too, she was disappointed with her husband. She had had two extramarital experiences which were characterized by strong emotional attachment and fondling with a strong feeling of closeness. However, neither of these led to sex intercourse because of refusal on the part of the man. These extramarital intimacies and relationships came nearest to what the patient emotionally desired of men. She kept up her fight for her activities and for her supremacy at home for some period after the development of her hypertension and secondary heart failures. But gradually, about two years after her first visits to the analyst, her confidence, and domineering position towards her husband were shaken, and she felt uncertain about her future.

Not long after these developments the patient began to manifest cutaneous symptoms. She had had five attacks of skin disturbance in the course of her lifetime, two of them occurring before this period. In the following, these five attacks will be described together with the attending circumstances and the construction of the psychodynamic background.

When the patient was five years old, the mother took her to a clinic, because she had some itching condition of the feet. She could not recall the diagnosis, but she was sure there had been no eruption, and the physician told the mother to "let the feet air."

The psychodynamics of this skin manifestation could be constructed only with probability because some essential information was missing. It is likely that the patient's complaint had to do with her sibling rivalry, her resentment toward her mother because of her injured self-love, and the frustration of her desire for exclusive affection. The skin complaint represented a plea of illness (helplessness), an attack on herself instead of the mother and the infant, and an identification with the infant. Occuring

during the oedipal period, it may have implied erotization of the skin as an expression of her sexual attachment to the father and a masturbatory equivalent.

When the patient was 14 years old, the following incident occurred: The parents were visiting a neighbor's house and the patient, returning home, went to get the key from her parents. She saw a man leaving the yard. It turned out that the man had entered the house and had stolen some jewels. The patient's mother became "hysterical", cried, and screamed. Following this, the patient developed a generalized itching lasting 24 hours. This attack represented an identification with the mother in several ways: it meant sympathy with her suffering, as well as an attack on her, expressing the patient's unconscious resentment; and punishing herself for the attack in the form of scratching. The itching represented also erotization of the whole skin surface, as if the mother and the patient herself had been attacked sexually, as if sexual treasures had been stolen from them.

Not long after her general perplexity developed as a result of her hypertension, the patient decided to spend the summer at the rival sister's house, with whom she now was on friendly terms. At this time, a passing dry, erythematous, scaly eruption appeared on the webs of her fingers when her husband visited her the first time during the summer and they had some clashes. This eruption had a background of resentment towards the husband for his rejecting coldness and his humiliating reluctance ever to admit to being in the wrong. It may have been correlated with her desire for aggressive use of the hands.

She returned home after the summer with improved spirits but the difficulties with her husband continued. Next summer, the patient went away for two months and decided that she would not return to him. After she made this decision, an erythematous, papular, scaly eruption appeared on the back of both of her hands, and, at the same time, her face became swollen, particularly under the eyes (angioneurotic edema), and the conjunctivae became hyperemic. Returning to the city, she was advised by her physician against leaving her husband, and the patient became depressed. Her depression continued, but the eruption on the back of her hands disappeared under soothing local treatment.

After two months of depression she re-entered analytic treatment. She gradually improved and again began to show overactivity and the domineering inability to acknowledge shortcomings. At the same time however, she was able to reveal very deep-seated feelings of loneliness, worthlessness, inadequacy and fear of abandonment, traceable back to sibling rivalry, conflict toward her parents and the man who disappointed her. She further recognized that the high-pressure organizational activity as well as

rivalry with men, particularly with her husband, was a compensation for her loneliness and feelings of worthlessness. The patient then expressed willingness to establish a close relationship with her husband if he, also, changed. The husband declined cooperation and the patient decided to leave him. A rather hectic period followed, characterized by the decision to leave, a fear of loneliness, difficulty in filling her life with satisfactory activity, and critical objections by the husband to her leaving on the grounds of unfairness to him and of public disapproval. The patient's angioneurotic edema and the dermatitis on the back of her hands reappeared in a more severe, exudative form. She had the following two dreams:

Dream I: The patient goes to a party and is forced to sit in a corner with shabby, dirty, dark skinned people, away from the main table. Then the place turns into a music hall. An old lady sends the patient for a chair. By the time the patient comes back, the performance is over.

Dream II: In a cold, snowy region in a cabin, the patient, her sister, and her brother-in-law are huddled together in close bodily contact because they are in danger of freezing to death. The patient's husband is in the process of bringing in wood to build a fire and to save them. The patient's brother-in-law and then her sister die. The patient thinks that the husband is not really trying to help, but is squandering the provisions. Her husband then reappears. He looks crazed and has a gun in his hand, and the patient pleads with him to let her live. The husband's eyes gradually turn into "just eyes", then into blue doll's eyes, and finally into the analyst's eyes.

In these dreams the patient utilized the whole body surface to express her conflicts and attempt a solution. The conflict was between a desperate need for love and care and a refusal to stay in a miserable situation of frustration and humiliation. The love and care was expressed in the form of warmth and bodily contact. The freezing to death was the fear of dying in a loveless state. The skin eruption was, on the one hand, an anguished cry of fear, an expression of feeling of debasement with strong anal coloring (shabby, dirty people with dark skin). On the other hand, it was an attempt to obtain the love and care. The patient's despair and anguish was shown by the fact that she was huddling, in the dream, with the sister who had been her rival and whom she had mistreated. In the first dream, the patient expressed the fear that she would not find a substitute for friendship anywhere from other people (she was forced to sit with inferior, repulsive people; she missed the musical performance—music at that time was her only sustained interest), but that she would be rejected, humiliated, considered inferior, and would not find fulfillment in any of her activities. Her mother was turning against her in the dream also (the old lady), and her husband would destroy her (genital attack) for past aggression. Probably, the itching and scratching had the secondary significance of attacking

her husband and also punishing herself for the attack. At the end of the dream hope was expressed that the analyst would give her the protection, affection and gratification denied to her by her husband. After the patient actually separated from her husband and stayed at a resort, the eruption responded to soothing local treatment. It became dry, smaller in size and paler.

It is of interest that while the patient was again spending time at her sister's and the sister expressed the view that the patient ought to return to her husband, the eruption became worse and the eczema started to weep. When the eruption first appeared, the emotional accent as indicated by the dreams, had been on fear of abandonment and attack, although self-debasement, humiliation and guilt were also present. When the relapse occurred, the patient felt deprived of the sister's affection, but the accent was on feelings of disapproval, self-condemnation, guilt and anger.

The patient left her husband permanently and, together with the lessening of her fear of abandonment as well as rise in her self-esteem, the patient's skin eruption disappeared almost entirely. She then had a mild, transient hemiplegic stroke. She was hospitalized for two weeks. She was afraid that she might become incapacitated, asked her husband to visit her in the hospital and at times asked him in a panicky manner just to hold her hand so she wouldn't feel alone and would not be afraid of dying.

She recovered entirely from the hemiplegia, although her blood pressure remained at a high level (210/110). Her anxiety subsided and she left for another state to arrange for her divorce.

Discussion

The cutaneous symptoms of the patient were correlated with stress patterns in which the need for love and care, anxiety, hostility, self-depreciation with anal coloring, and guilt played a dominant role, together with erotization of the skin surface. With differences in the patient's life situation and in her emotional constellation, the nature of the skin manifestations altered. However, the established skin symptoms suffered an exacerbation even with a shift in the patient's dominant conflict pattern.

It is of further interest to consider the psychodynamics of the patient's other psychological and psychosomatic manifestations: the dominant character trait of excessive activity, of having to dominate situations, and always having to be right; arterial hypertension; severe psychoneurotic depression, and overt anxiety.

The patient had solved the conflicts arising out of frustrated self-love and desire for exclusive affection, the hostility toward the sibling and toward the parents, her oedipal strivings, and fear of genital injury, mainly on the pattern of her relationship with the sister four years younger than

she: through aggression, superiority, domination, and achievement. The undercurrent need for affection, closeness and femininity was unsatisfied. She tried to satisfy this when she fell in love with the man who later jilted her. To this then she reacted with depression. The concomitant of the excessive activity and continuous domination was her hypertension. When she could not continue the sustained drive she turned to her husband for affection, felt frustrated, and became depressed as a result of loss of love, rejection, humiliation and guilt. When she regained sufficient strength and self confidence (with substitutive care and affection) she decided to leave her husband, but as a result of the intensified fear of loneliness, anticipated condemnation, humiliation and guilt, she developed a skin disorder.

This series of developments indicates that the fundamental personality features, the broad emotional needs which motivated the patient, played a dominant role in the development of all the above mentioned disorders. Life situations and emotional constellations changed, and parallel with them the dominant psychopathological and psychosomatic manifestations changed. There were special determining elements in the special constellation. There were shifts in relative emphasis on various aspects of the emotional patterning, but some common fundamental elements were present in the dynamics of all of the manifestations. Thus both the concept of specificity and of non-specificity of psychodynamic patterning seem applicable.

Summary

1) The conflicting trends that were found correlated with the skin disorders here presented were the longing for affection and care, the fear of abandonment and attack, feelings of helplessness, hostility, aggression, hurt self-esteem, guilt, self-depreciation and self-debasement with anal coloring, and erotization of the skin. The fantasy content was that of obtaining love and care through warmth and cutaneous contact.

2) The skin reactions changed their character with changes in the external traumatic situation and the internal conflict pattern.

3) Once a skin pathology was established, the same pathological reaction could occur with shift in the dominant conflict pattern.

4) Broad, emotional needs and drives, such as need for love and care, hostility, erotic strivings, anxiety and guilt, were vital in the dynamics of the skin pathology, and the same broad needs led to anxiety attacks, depressive reactions, and characterological manifestations.

5) "Specificity" in the dynamics of these manifestations implied relative change in accent on various aspects of the emotional constellation and also the appearance of some unique fantasy elements. However, the non-

specific aspects were as important in the total dynamics of the respective reactions as the specific ones.

REFERENCES

1. Mittelmann, B., and Wolff, H. G.: Affective States and Skin Temperature: Experimental Study of Subjects with "Cold Hands" and Raynaud's Syndrome. *Psychosomatic Medicine.* 1:271, 1939.
2. Mittelmann, B., and Wolff, H. G.: Emotions and Skin Temperature: Observations on Patients During Psychotherapeutic (Psychoanalytic) Interviews. *Psychosomatic Medicine.* 5:211, 1943.
3. Saul, L. J., and Bernstein, C.: The Emotional Settings of Some Attacks of Urticaria. *Psychosomatic Medicine.* 3:4, 1941.
4. Deutsch, F., and Nadell, R.: Psychosomatic Aspects of Dermatology with Special Consideration of Allergic Phenomena. *The Nervous Child.* 5:339, 1946.

ANNOUNCEMENT

The editors regret to announce the departure of a long-time member of their board and a frequent contributor to the *Bulletin of the Menninger Clinic*. Dr. Robert P. Knight, Chief of Staff of the Menninger Clinic, Trustee and Vice-President of the Menninger Foundation and an editor of the Bulletin, has accepted the position of Medical Director at The Austen Riggs Foundation, Inc., Stockbridge, Massachusetts as of September 1st, 1947.

Dr. Knight has been on the staff of the Menninger Clinic for fourteen years having come to Topeka in July, 1933. He has been continuously associated with the development of the clinical and educational programs and has also made numerous contributions to its research work, particularly in the field of psychotherapy.

Probably his greatest contribution to psychiatry, however, has been in the field of teaching where his clear thinking, his able expression, and his grasp of psychiatric and psychoanalytic theory have been inspirational to many students throughout the United States. He will be greatly missed in the Menninger Foundation School of Psychiatry by both faculty and students.

While regretting our own loss as editors, and that of the whole Foundation, we hope to continue to claim a share of his thought and interest, as he will always share ours. We wish him all success in his new position and congratulate the institution to which he is going upon its acquiring a fine gentleman, a good physician, and an inspiring teacher.

The Editors

BOOK NOTICES

The Dynamics of Human Adjustment. By PERCIVAL M. SYMONDS. Price $5.00. Pp. 666. New York and London, D. Appleton-Century Company, 1946.

It was gratifying at first when browsing through Symonds' book, to see that he followed Freud in the bulk of his text, and that he also with evident good will tried to incorporate points of view and observations of Adler, Rank, Reich, Reik, Horney, Klein, and of various schools of academic psychology. But it is, of course, quite difficult to attempt a synthesis of the divergent views, and much more than good will is needed to achieve a better effect than the cook did who, considering that chocolate cake was good and garlic was good, served chocolate cake with garlic. I believe that Symonds succeeded in producing a very extensive compilation, but not a synthesis. The author no doubt is well read, but probably lacking in sufficient clinical experience to select his material critically. He apparently hated to reject, was rather liberal in accepting and not too sensitive as to contradictions between the formulations coming from different sources. (P. Bergman)

Shock Treatments and Other Somatic Procedures in Psychiatry. By LOTHAR KALINOWSKY and PAUL H. HOCH. Price $4.50. Pp. 294. New York, Grune & Stratton, 1946.

Any physician who is engaged in the practice of psychiatry should read this book—especially physicians working in institutions. The authors are well known for their extensive work in the so-called shock therapies, and have done a commendable and laborious task of reviewing the vast amount of literature on this subject. They call attention to the empirical status of many of the somatic therapies, and to the confused, contradictory, prejudiced and misleading contributions to the subject.

This reviewer found the book comprehensive—dealing with historical considerations, insulin shock, convulsive therapies, combined insulin-convulsive treatment, pharmacotherapeutic agents (sodium amytal, pentothal, benzedrine, dilantin), continuous sleep, fever therapy, nitrogen inhalation, vascular shock (histamine, acetylcholine), faradic shock, refrigeration therapy and electric narcosis. All of these subjects are dealt with in great detail, and the most admirable contributions as to technique, hazards, etc., are in the chapters on insulin and electric convulsive therapy. The most stimulating chapters occur at the end of the book—on prefrontal lobotomy and theoretical consideration.

The authors state: "The shock treatments today are indispensable tools of psychiatric therapy; they will stay with us until better methods are evolved." This is certainly true and should stimulate all those interested to study and reflect on the problem. The authors, and shock enthusiasts in general, apparently feel defensive about the opprobrium surrounding the term "shock" therapies, and object to the connotation of sadistic assault, (physiologic and psychic), and the physiologists and pathologists object because of the dissimilarity with vascular shock. Those people who have had experience with the shock therapies, whether as attending physicians

or as patients, will find it difficult to find a more euphemistic term. (Harlan Crank)

The Normal Encephalogram. By LEO M. DAVIDOFF, M.D. and CORNELIUS G. DYKE, M.D.: Second Edition. Price $5.50. Pp. 232. Lea and Febiger, Philadelphia, 1946.

This book which on the surface appears to deal with a very technical subject has more than that apparent limited use. It can be very valuable in the teaching of applied anatomy, surface markings and as an aid in accurate visualization of the anatomy of the intracranial contents. The arrangement of the chapters is excellent and permits one to follow consecutively the subject matter without interruption. Wherever possible the history of the pioneer work has been noted and enables one to appreciate the comparatively recent development of the high standard in this additional phase of investigation of the nervous system. The photographs and drawings are excellently portrayed and labeled. Doctor Davidoff is to be commended upon the continuation of the high standard in the second edition without the help of his late colleague, who unfortunately died so prematurely in 1943. This book is a valuable asset to everyone whose work or interest is related to the central nervous system; it is a classic within its field. (Leon L. Bernstein)

Handbook for Psychiatric Aides. BY FRANK L. WRIGHT, JR., EDITOR, AND OTHERS. Price $0.50. Pp. 58. Philadelphia, National Mental Health Foundation, 1946.

This is an excellent little paper backed volume which should serve as a good introduction to the attendant or nurse's aide new to the field of psychiatry. It is simply written, concise, and the language is understandable to almost anyone. Each chapter has a suggested reading list which is excellent and there is a very simple glossary in the back of the most common terms used. There is an innovation which the reviewer thinks of great value; a very brief history of psychiatry is presented as the last chapter rather than the usual first chapter. As a good down-to-earth introduction to psychiatric attendants work, this seems like the best one available to date. The chapter on common types of mental disorders is neat, concise and simple, and seems to follow the army's nomenclature. (M. Olga Weiss)

Group Psychotherapy, Theory and Practice. BY J. W. KLAPMAN, M.D. Price $4.00. Pp. 344. New York, Grune and Stratton, 1946.

This book contains brief stimulating descriptions of some of the various group methods. Group psychotherapy is conceived of as a re-educational process with two aspects: an affective and an orientative. It is presented as an adjunct to individual therapy especially to bring about psychological-mindedness, but there is the implication that it may be the method of choice because of financial or temporal considerations.

After a short historical review, there is a section on dynamics which superficially discusses the transference, interaction of group members, catharsis, abreaction and the advantages peculiar to group methods because re-adjustment takes place in a social situation. The remainder

of the book is devoted to the practical aspects of conducting groups, presented in such a manner as to indicate possible applications. The main shortcoming is the insufficient consideration of the many difficulties frequently encountered in this type of treatment. (Peter D. Fleming)

Group Psychotherapy. A Symposium. Edited By J. L. Moreno. Price $5.00. Pp. 305. New York, Beacon Hill, 1946.

This book is a volume in the Sociometric Series and thus a proportionately large amount of the text is concerned with this approach to group treatment. In addition to various papers on psychodrama, sociodrama, sociometric methods, music, dance and so forth, there are some extracts from the Round Tables on Group Psychotherapy held in 1932 and 1944 and also brief considerations of lecture and analytic type group treatment methods.

Several articles are specifically recommended: Ackerman's on the theoretical aspects of group psychotherapy brings some order to the confusion in the field: Louise Sullivan's on children; and one by Joseph Pratt, which though non-psychiatric is interesting historically, since he is one of the American pioneers in group treatment. In order to follow all of the material in this work, a knowledge of the techniques of the Moreno School is helpful. (Peter D. Fleming)

Manual of Diagnostic Psychological Testing. II. The Diagnostic Testing of Personality and Ideational Content. By David Rapaport and Roy Schafer, With the Collaboration of Merton Gill. Price 75¢. Pp. 105. New York, Josiah Macy, Jr. Foundation, 1946.

This is the second of three short volumes devoted to a presentation of the diagnostic potentialities of the battery of psychological tests being used by the Psychology Department of the Menninger Clinic. The manuals are essentially compact summaries of a two-volume monograph, *Diagnostic Psychological Testing*, published in 1945 and presenting fully the research data and their psychological implications concerning this battery of psychological tests. The monograph has been reviewed in a previous issue of the *Bulletin* by Dr. Paul Bergman so that here it only needs to be mentioned that Volume II of the manual concerns itself with the diagnostic implications of the Rorschach Test, the Thematic Apperception Test, and a Word Association Test. The third volume of the manual to appear sometime in the future will present analyses of the test results on specific cases falling into a large variety of different nosological groups; it will attempt to demonstrate how the research findings and psychological concepts previously presented can be synthesized in the study of any single case in order to achieve a diagnostic impression as well as a description of significant aspects of the patient's personality and maladjustment. (Roy Schafer)